

CLINICAL AIDS

Disease	Diagnosis Date (mm/dd/yyyy)	dx method ⁵	
		Presumptive	Definitive
Candidiasis, bronchi, trachea, or lungs	___/___/___		<input type="checkbox"/>
Candidiasis, esophageal	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Cervical cancer, invasive	___/___/___		<input type="checkbox"/>
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptococcosis, extrapulmonary	___/___/___		<input type="checkbox"/>
Cryptosporidiosis, chronic ⁶ intestinal	___/___/___		<input type="checkbox"/>
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___		<input type="checkbox"/>
Cytomegalovirus retinitis (with loss of vision)	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
HIV encephalopathy	___/___/___		<input type="checkbox"/>
Herpes simplex: chronic ⁶ ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___		<input type="checkbox"/>
Histoplasmosis, diss. or extrapulmonary	___/___/___		<input type="checkbox"/>
Isosporiasis, chronic ⁶ intestinal	___/___/___		<input type="checkbox"/>
Kaposi's sarcoma	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma, Burkitt's (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, immunoblastic (or equivalent)	___/___/___		<input type="checkbox"/>
Lymphoma, primary in brain	___/___/___		<input type="checkbox"/>
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, pulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
M. tuberculosis, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumocystis pneumonia	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia, recurrent ⁷	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Progressive multifocal leukoencephalopathy	___/___/___		<input type="checkbox"/>
Salmonella septicemia, recurrent	___/___/___		<input type="checkbox"/>
Toxoplasmosis of brain	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>
Wasting syndrome due to HIV ⁸	___/___/___		<input type="checkbox"/>

Return completed form to:

Public Health
Seattle & King County



HIV/AIDS Epidemiology Program
400 Yesler Way, 3rd Floor
Seattle, WA 98104
(206)296-4645

FOOTNOTES

¹Patient identifier information is not sent to CDC.

²Outpatient dx: ambulatory diagnosis in a physician's office, clinic, group practice, etc.

Inpatient dx: diagnosed during a hospital admission of at least one night.

³After 1977 and preceding the first positive HIV antibody test or AIDS diagnosis.

⁴If case progresses to AIDS, please notify health department.

⁵If further clarification of definitive and presumptive diagnostic methods is needed, please contact health department.

⁶Chronic: more than one month's duration.

⁷Recurrent: 2 or more episodes within a 1-year period.

⁸Wasting syndrome due to HIV infection includes >10% weight loss plus 1) chronic diarrhea and/or 2) fever and chronic weakness lasting over 30 days in absence of a concurrent illness other than HIV which could explain the findings (e.g., cancer, TB, cryptosporidiosis, or other specific enteritis).

FOR HEALTH DEPARTMENT USE ONLY

ID Code

FUI Assigned:

☐ Complete☐ Incomplete☐ OOS

RVCT Number:

WASHINGTON STATE
REPORTING REQUIREMENTS

AIDS and HIV infection are reportable to local health authorities in Washington in accordance with WAC 246-101. HIV/AIDS cases are reportable within 3 working days and reporting does not require patient consent.

ASSURANCES OF CONFIDENTIALITY AND
EXCHANGE OF MEDICAL INFORMATION

- Several Washington State laws pertain to HIV/AIDS reporting requirements. These include: Maintain individual case reports for AIDS and HIV as confidential records (WAC 246-101-120,520,635); protect patient identifying information, meet published standards for security and confidentiality if retaining names of those with asymptomatic HIV, (WAC 246-101-230,520,635); investigate potential breaches of confidentiality of HIV/AIDS identifying information (WAC 246-101-520) and not disclose HIV/AIDS identifying information (WAC 246-101-120,230,520,635 and RCW 70.24.105).
- Health care providers and employees of a health care facilities or medical laboratories may exchange HIV/AIDS information in order to provide health care services to the patient and release identifying information to public health staff responsible for protecting the public through control of disease (WAC-246-101-120, 230 and 515; and RCW 70.24.105).
- Anyone who violates Washington State confidentiality laws may be fined a maximum of \$10,000 or actual damages; whichever is greater (RCW 70.24.080-084).

FOR PARTNER NOTIFICATION INFORMATION

- Washington state law requires local health officers and health care providers to provide partner notification assistance to persons with HIV infection (WAC 246-100-209) and establishes rules for providing such assistance (WAC 246-100-072).
- For assistance in notifying spouses, sex partners or needle-sharing partners of persons with HIV/AIDS, please call HIV/AIDS Prevention & Education Services, DOH, at (360) 236-3422, or your local health department. In King County, please call Edith Allen, Public Health Seattle & King County, at (206) 744-4377.

Comments:

Date King Co. received the report
indicative of a new HIV infection:

□	□	/	□	□	/	□	□	□	□
Month			Day			Year			

Patient Name ¹ (Last, First, Middle):		
AKA (Nickname, Previous Last Names, etc.)		
Phone #: () -	Social Security #: - -	
Current Street Address:		
City:	Zip Code:	[1] Alive [2] Dead
Birthdate (mm/dd/yyyy) / /	Death Date (mm/dd/yyyy) / /	State of Death:
Sex at birth: [1] Male [2] Female	Gender or identity change: [1] Male to Female [2] Female to Male	Ethnicity: [1] Hispanic [2] Not Hispanic
Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian/Alaska Native		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never married <input type="checkbox"/> Unknown
Country of birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____ If other, length of residence in US: _____		
Was patient dx in another state? [1] Yes [2] No If yes, specify state: _____		
Residence at time of diagnosis if different than current address: City: County: Zip Code:		
Med. Record #/Patient Code:		
Name & City of facility of diagnosis:		
[1] Outpatient dx ² [2] Inpatient dx ²		

PROVIDER INFORMATION		
Physician:	Phone:	City:
Person reporting if other than physician: Phone:		

PATIENT HISTORY SINCE 1977 ³			
Check all that apply	Yes	No	Unk
Sex with male.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex with female.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection drug use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received clotting factors for hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion, Transplant, or Insemination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heterosexual relations with:			
Injection drug user.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual man.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person with hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV transfusion or transplant....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PWA/HIV risk not specified.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worked in health-care or laboratory setting..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, occupation: _____			

CONFIDENTIAL HIV/AIDS ADULT CASE REPORT			
LABORATORY DATA ⁴			
Test Date (mm/dd/yyyy)			
Last documented negative test ____/____/____ Type of test: _____			
EARLIEST POSITIVE HIV ANTIBODY TESTS:			
Type of Test:	Test Date (mm/dd/yyyy)		
HIV-1 EIA	____/____/____	<input type="checkbox"/> Test not done	
HIV-1 Western Blot or IFA	____/____/____	<input type="checkbox"/> Test not done	
HIV VIRAL LOAD TESTS:			
Type of Test:	Test Date (mm/dd/yyyy)		
Earliest HIV Viral Load	____/____/____	<input type="checkbox"/> Copies per mL <input type="checkbox"/> Undetectable	
Most recent HIV Viral Load	____/____/____	<input type="checkbox"/> Copies per mL <input type="checkbox"/> Undetectable	
OTHER HIV TESTS			
Type of test: Rapid, Culture, HIV-2, Combined Ab/Ag _____			
Date (mm/dd/yyyy): ____/____/____		Result: _____	
PHYSICIAN DIAGNOSIS OF INFECTION:			
No laboratory tests are available but Physician documents HIV infection Date (mm/dd/yyyy): ____/____/____			
EARLIEST DRUG RESISTANCE TEST			
Date (mm/dd/yyyy): ____/____/____		<input type="checkbox"/> Test not done	
Type: Genotype Phenotype			
Laboratory: _____			
CD4 LEVELS			
Type of Test:	Test Date (mm/dd/yyyy)	Count	Percent
Earliest CD4	____/____/____	_____ cells/μl	_____ %
Most Recent CD4	____/____/____	_____ cells/μl	_____ %
First CD4 <200 μl or < 14%	____/____/____	_____ cells/μl	_____ %

TREATMENT / SERVICES REFERRALS				
	Yes	No	Unk	NA
Has this patient been informed of his/her HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
This patient is receiving/has been referred for:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• HIV related medical service				
• HIV Social Service Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This patient received/ is receiving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Antiretroviral (ARV) therapy				
If yes, earliest date started ARV after diagnosis (mm/dd/yyyy): ____/____/____				
• PCP prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FOR WOMEN				
Is this patient currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	Unk	
Expected delivery date (mm/dd/yyyy) ____/____/____				

HEALTH DEPARTMENT USE ONLY		
<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS	Stateno: _____
Date: ____/____/____	Source: _____	
<input type="checkbox"/> New Case	<input type="checkbox"/> Progression	<input type="checkbox"/> Update, no status change

Note AIDS indicator diseases on reverse
<input type="checkbox"/> CHECK HERE IF PATIENT HAS NO AIDS INDICATOR DISEASES If checked, skip Clinical AIDS section on reverse.

HIV TESTING HISTORY	
Complete this section if new diagnosis or new patient	<input type="checkbox"/> Not applicable
OR attach completed questionnaire	

Date patient reported info (mm/dd/yyyy): ____/____/____
Information from: <input type="checkbox"/> patient interview <input type="checkbox"/> review of medical record <input type="checkbox"/> provider report <input type="checkbox"/> PEMS <input type="checkbox"/> other

FIRST SELF-REPORTED POSITIVE HIV TEST
Ever had a previous positive test? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown
Date of first positive test (mm/yyyy): ____/____/____

LAST SELF-REPORTED NEGATIVE HIV TEST
Ever had a negative test? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown
Date of last negative test (mm/yyyy): ____/____/____

OTHER HIV TESTS
Number of negative HIV tests in 24 months before first positive test: _____
<input type="checkbox"/> Refused <input type="checkbox"/> Unknown

ANTIRETROVIRAL (ARV) USE (including prophylaxis)
Ever taken any ARV: Yes No Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes: Names of medications used: _____
Date first began (mm/dd/yyyy): ____/____/____
Date of last use (mm/dd/yyyy): ____/____/____

DRUG USE
Methamphetamine use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
If, yes: <input type="checkbox"/> Injection <input type="checkbox"/> Non-injection, specify: _____ <input type="checkbox"/> Unk

PARTNER SERVICES NOTES